DSHS – Management Services Administration

Social Services Payment System (SSPS)

HIPAA Rule 1 Data Gap Analysis

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1 Executive Summary

1.1 Goal

Since all payers must support all electronic HIPAA transactions if they correspond to any of the payer's business processes, whether manual or electronic, SSPS must support the following HIPAA transactions:

837P-Healthcare Claim – Professional
837I-Healthcare Claim - Institutional
837D-Healthcare Claim - Dental
276/277-Claim Status Inquiry and Response
835-Remittance Advice

1.2 Method

The purpose of HIPAA Data Gap Analysis is to identify detailed programming/field-level issues which need remediation in order for SSPS to be HIPAA compliant. The steps to accomplish this include:

1. Identify the DSHS administrations' business processes that correspond to HIPAA transactions
2. Perform data mapping (comparisons) between HIPAA transactions and legacy records
3. Identify and document the HIPAA data analysis gaps

1.3 Results

HIPAA business processes were identified for which data mapping should be done. All of these have been mapped and the results are documented here.

The major gaps are summarized as follows:

- 4 fields listed in SSPS HIPAA Compliance documents cannot be mapped into a HIPAA transaction.
- For 837 Professional:
  - 6 required HIPAA data elements are not available from the legacy system,
  - Local service codes must be mapped to standard HCPCS codes.
- For 837 Institutional:
  - 12 required HIPAA data elements are not available from the legacy system,
  - 3 local code sets must be mapped to standard codes.
- For 837 Dental:
  - 10 required HIPAA data elements are not available from the legacy system,
  - Local service codes must be mapped to standard HCPCS codes.
- For 835 Remittance:
  - 2 required HIPAA data elements are not available from the legacy system,

- complex logic to handle the rare adjustment must be supported,
- Data elements from the 837 claim must be stored and returned in the 835,
- Local service codes must be mapped to standard HCPCS codes.

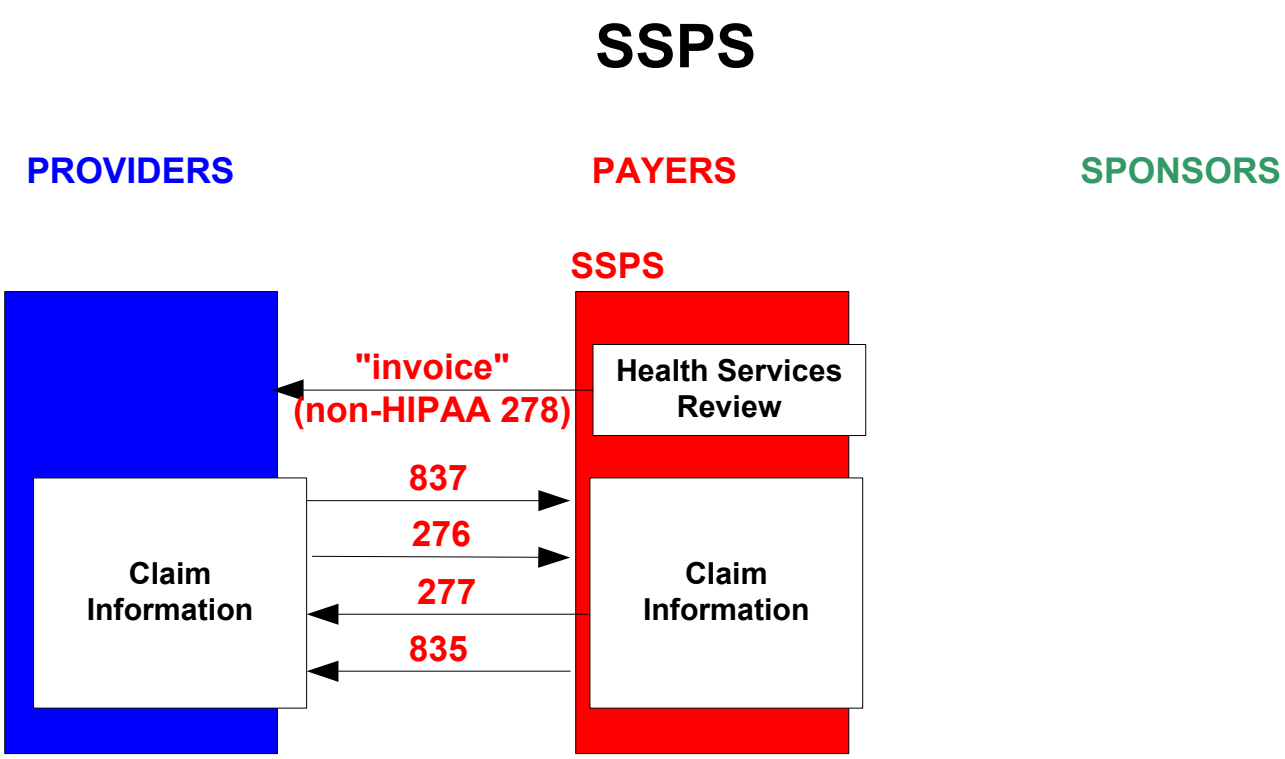
2 Identify Transactions (Step 1)

The first step is to identify which business processes must be HIPAA compliant, by comparing the HIPAA transactions (tx) descriptions with the business processes. This was partially accomplished by the Sierra business analysts and documented in their Deliverable I, and was refined during more recent discussions between Joe Barton, SSPS, and Francine Kitchen, HIPAA Consultant.

The following table shows the HIPAA processes that should be supported.

HIPAA Transaction	SSPS Process
278-Authorization Notification	SSPS notifies the provider that they have been authorized to provide specific services to a specific client. SSPS refers to this as an "invoice" or a "pre-paid claim". In HIPAA terms, this is an unsolicited Prior Authorization, which is not yet a mandated transaction, but probably will be in the next version of HIPAA. Mapping of this transaction was not requested.
837P-Healthcare Claim - Professional	SSPS receives requests from providers for payment for professional services rendered.
837P-Healthcare Claim - Professional	SSPS receives requests from providers for payment for institutional services rendered.
837P-Healthcare Claim - Professional	SSPS receives requests from providers for payment for dental services rendered.
276/277-Claim Status Inquiry and Response	Under HIPAA, any entity which receives claims and sends payments must also support a claim status inquiry if requested to do so by a provider. Mapping of this transaction was not requested.
835-Remittance Advice	SSPS sends remittance advice to providers when a claim is paid.

The following diagram shows a broader picture of the SSPS business processes, which correspond to HIPAA transactions.



3 Data Mapping (Step 2)

The second step of data gap analysis is to compare the HIPAA data elements to the legacy system data elements (fields). For example, if the administration's current information system will need to support a HIPAA claim status response, then it must contain a status code for each claim, because that is a required data element in the HIPAA transaction. The goal of data mapping is to identify:

- Where each legacy field will fit in the HIPAA transaction,
- Any HIPAA required data elements that are not stored in the legacy system,
- Any legacy system data elements that have no place to be sent in the HIPAA transaction,
- Any legacy system data elements that need to be longer to support HIPAA byte lengths,

A similar analysis must be done to identify all local codes that must be converted to standard codes. That was the responsibility of the Local Codes TAG (lead by Katie Sullivan), and is beyond the scope of this data mapping project.

For the other DSHS Administrations, the WPC OnlyConnect gap analysis tool was used. But for SSPS, a review based only on field names was requested. Without a record layout from the legacy system, showing data field byte lengths, the OnlyConnect Tool cannot be used. This also means that no comparison could be done of which legacy field lengths are too short

for HIPAA. Instead, field names appearing in various SSPS documents were mapped to HIPAA data elements in EXCEL spreadsheets.

The mapping reports that were generated should be used not only for gap analysis, but also for implementation (in conjunction with the HIPAA Implementation Guides). The mapping reports contain HIPAA data elements that are mapped to legacy fields with processing comments.

Filename	Description
HIPAA 837P to SSPS.xls	837P-Professional Claim
HIPAA 837I to SSPS.xls	837I-Institutional Claim
HIPAA 837D to SSPS.xls	837D-Dental Claim
HIPAA 835 to SSPS.xls	835-Remittance Advice

4 Identify Gaps (Step 3)

This section lists all the data issues that should be addressed in order to comply with HIPAA Rule 1 for this administration, as well as is known based on discussions with administration representatives. Based on the data mapping described in the previous section, the following sections describe the data gaps discovered. In the following tables, "Transaction", "Loop", and "Segment" identify the position of the data elements within the HIPAA transactions.

4.1 Common Analysis for All Transactions

4.1.1 Legacy Fields Too Short for HIPAA

HIPAA Rule 1 mandates that no data be truncated. So if data is received via a HIPAA transaction (e.g., 837) that is longer than the current field where it would be stored, AND that data would ever need to be sent back out in another HIPAA transaction (e.g., 835), then the longer length must be accommodated.

As noted above, legacy system byte lengths were not available for SSPS data. Without a record layout from the legacy system, showing data field byte lengths, no comparison could be done of which legacy field lengths are too short for HIPAA.

4.1.2 Required Data That May be Defaulted or Derived

Some data elements were determined to be required under the HIPAA guidelines that do not have a corresponding data element on the current system, but are of such a nature that they may be defaulted or derived outside of the normal business process, that is, by the implemented software (clearinghouse, translator, etc.). The mapping spreadsheet contains

notes about literals and default values that should be used in these cases. No gap is involved in these cases.

4.1.3 Legacy Data No Longer Used

Many data elements are currently provided by the legacy system, but are not included in the HIPAA transaction. Thus it will no longer be possible for SSPS to provide this information for this transaction. SSPS must determine for each of these, whether a work-around will be needed. Not all the SSPS legacy data was analyzed, since only a few fields are used in current data interchanges. Below are the legacy fields which were mentioned in SSPS HIPAA documentation, but which have no place to be sent in the HIPAA transactions.

SSPS Field	
Treasurer's ID #	
Treasurer's EIN	
Total number claims	
Total Units Claimed	Can send in 837P and 837I, but not 837D

4.2 278 Notification of Authorization of Service

For a social services model, enrollment and authorization of specific services by specific providers happens at the same time—when a case worker does assessment of a client. There is no pre-defined "plan" which makes the client eligible for types of service (as in a medical model), only certain services which are authorized. Social services "enrollment" requires that the case worker notifies the payer and provider of authorized services.

For this purpose, the non-HIPAA 278 Notification transaction can be used. Alternatively, legacy processes can continue. But the 278 Notification may become a mandated HIPAA transaction in the future. So it may be more efficient in the long run, to implement it when the other HIPAA transactions are implemented.

Mapping of this transaction was not requested.

4.3 837P – Healthcare Claim - Professional

Payers must support the HIPAA electronic claim transaction. The Professional claim is used for billing professional services (usually individual provider services which tend to be based on individual procedures), as opposed to institutional services (which tend to be based on time periods and require admission data unless they're outpatient institutional services), or dental services.

4.3.1 837P: HIPAA Required Data Not Available From Legacy System

The following data elements are required under the HIPAA guidelines, but not currently available on the SSPS system. These data elements must either be developed, derived or defaulted in order for the resultant transaction to be HIPAA compliant.

Loop	Segment	Data Element	Comment
Submitter	NM109	Submitter ID	Need local ID, not EIN/NPI
Subscriber	N3, N4	Subscriber Address	Required if subscriber = patient
Subscriber	NM109	Payer ID	Need local ID, not EIN/NPI
Claim	CLM11	Related Causes Information	Required if accident or work related
Claim	DTP03	Date - Accident	Required if accident related
Claim	NM109	Rendering Provider ID	EIN/NPI Required if rendering <> billing/pay-to provider

4.3.2 837P: HIPAA Code Set Usage

Beyond the format and data elements that must be used, the implementation guides for the HIPAA transaction dictate the required code sets to be utilized in certain data elements. Based upon our analysis of the current SSPS business process, SSPS should convert to the following standard code sets.

Loop	Segment	Data Element	Legacy Field	HIPPA Code Set
Service	SV101	Procedure Code	SERVICE CODE	Map to HCPCS codes

4.3.3 837P: Looping

HIPAA transaction formats contain complex looping structures to allow repetition of sets of related data. The software that parses the incoming transaction will need to accommodate optionally:

- Many billing providers in one transaction (no upper limit),
- Many clients for each billing provider (no upper limit),
- Up to 100 claims for each client,
- Up to 50 service line items for each claim.

4.4 837I – Healthcare Claim - Institutional

4.4.1 837I: HIPAA Required Data Not Available From Legacy System

The following data elements are required under the HIPAA guidelines, but not currently available on the SSPS system. These data elements must either be developed, derived or defaulted in order for the resultant transaction to be HIPAA compliant.

Loop	Segment	Data Element	Comment
Submitter	NM109	Submitter ID	Need local ID, not EIN/NPI
Subscriber	N3, N4	Subscriber Address	Required if subscriber = patient
Subscriber	NM109	Payer ID	Need local ID, not EIN/NPI
Claim	DTP03	Discharge Hour	Required if inpatient was discharged
Claim	DTP03	Statement from or To Date	Required: (for inpatients this is admit-discharge unless billing period < admit-discharge)
Claim	DTP03	Admission Date/Hour	Date and hour required if inpatient
Claim	CL101	Admission Type Code	Required if inpatient
Claim	CL102	Admission Source Code	Required if inpatient or Medicaid outpatient
Claim	CL103	Patient Status Code	Required if inpatient
Claim	HI01-1	Principal Procedure Code	Required if inpatient procedure(s) or home IV or visit after inpatient surgery
Claim	NM109	Attending Provider ID	EIN/NPI Required if rendering <> billing/pay-to provider
Service	SV201	Service Line Revenue Code	Required

4.4.2 837I: HIPAA Code Set Usage

Beyond the format and data elements that must be used, the implementation guides for the HIPAA transaction dictate the required code sets to be utilized in certain data elements. Based upon our analysis of the current SSPS business process, SSPS should convert to the following standard code sets.

Loop	Segment	Data Element	Legacy Field	HIPPA Code Set
Claim	CLM05-1	Facility Type Code	FACILITY TYPE CODE	Map to valid values in Guide
Claim	CLM09	Release of Information Code	RELEASE OF INFORMATION CODE	Map to valid values in Guide
Service	SV101	Procedure Code	SERVICE CODE	Map to HCPCS codes

4.4.3 837I: Looping

HIPAA transaction formats contain complex looping structures to allow repetition of sets of related data. The software that parses the incoming transaction will need to accommodate optionally:

- Many billing providers in one transaction (no upper limit),
- Many clients for each billing provider (no upper limit),
- Up to 100 claims for each client,
- Up to 999 service line items for each claim.

4.5 837D – Healthcare Claim - Dental

4.5.1 837D: HIPAA Required Data Not Available From Legacy System

The following data elements are required under the HIPAA guidelines, but not currently available on the SSPS system. These data elements must either be developed, derived or defaulted in order for the resultant transaction to be HIPAA compliant.

Loop	Segment	Data Element	Comment
Submitter	NM109	Submitter ID	Need local ID, not EIN/NPI
Subscriber	N3, N4	Subscriber Address	Required if subscriber = patient
Subscriber	NM109	Payer ID	Need local ID, not EIN/NPI
Claim	CLM11	Related Causes Information	Required if accident or work related
Claim	DTP03	Date - Accident	Required if accident related
Claim	DTP03	Related Hospitalization Admission Date	Required if inpatient
Claim	DTP03	Discharge or End Of Care Date	Required if inpatient was discharged
Claim	NM109	Rendering Provider ID	EIN/NPI Required if rendering <> billing/pay-to provider
Service	TOO02	Tooth Code	Required if proc relates to a certain tooth or teeth
Service	TOO03-1	Tooth Surface Code	Required if proc relates to a certain tooth or teeth

4.5.2 837D: HIPAA Code Set Usage

Beyond the format and data elements that must be used, the implementation guides for the HIPAA transaction dictate the required code sets to be utilized in certain data elements. Based upon our analysis of the current SSPS business process, SSPS should convert to the following standard code sets.

Loop	Segment	Data Element	Legacy Field	HIPPA Code Set
Service	SV101	Procedure Code	SERVICE CODE	Map to HCPCS codes

4.5.3 837D: Looping

HIPAA transaction formats contain complex looping structures to allow repetition of sets of related data. The software that parses the incoming transaction will need to accommodate optionally:

- Many billing providers in one transaction (no upper limit),
- Many clients for each billing provider (no upper limit),
- Up to 100 claims for each client,
- Up to 50 service line items for each claim.

4.6 835 – Remittance Advice

Payers must support the HIPAA electronic remittance advice transaction.

4.6.1 835: HIPAA Required Data Not Available From Legacy System

The SSPS 835 documentation is only filename "element flow", title "SSPS Generated Information, Payee Generated Information, Draft, December 17, 2001". In this document there is no distinction made between data that are already used in SSPS versus data intended to be developed for HIPAA compliance. Therefore, a true legacy to HIPAA comparison could not be done. A spreadsheet mapping field names to HIPAA data elements has been created, which shows which ones are required. Below are listed the required HIPAA data elements that are not listed in the SSPS document.

Loop	Segment	Data Element	Comment
Payer	N104	Payer Identifier	Need Nat'l Plan ID, not EIN
Claim	NM103	Corrected Patient or Insured Last Name	Required if 837 name <> 835 name

4.6.2 835: Adjustments

Whenever the claim/billed amount is different than the paid/remitted amount, special segments must be included in the 835 with a reason code for each dollar amount that's different. Various kinds of adjustments require different handling. The 835 Guide explains the detail. The following is a description of some of the possible scenarios to support.

If a provider bills for a higher rate than authorized, a **service level adjustment** must be created. To create the required transaction some of the fields needed are: procedure code, billed amount, authorized amount. Otherwise the 835 will not "balance" and it will be invalid.

When the SSPS "pre-paid claim" (278) is created a record will be stored that contains the maximum allowed amount for the HIPAA transaction. If the wrong rate is on the 837 it will be changed to the allowed rate. The 835 must compare the rates and send segments that show the requested amount, the reason for the difference in the rates and the paid amount.

Provider Submits a Correction for More Than Originally Billed:

Positive adjustments can be handled by treating it as another claim. But negative adjustments cannot.

If the provider submits an electronic correction (resubmit) to a previously submitted claim for MORE than originally billed, the translator must recognize this and send to MMIS only the part that wasn't already paid. So the translator must store all claims for as long as any correction is allowed, and when a correction is received, compare billed amounts and units of service. This requires a claim unique ID (invoice number [CPL01 provider claim#], plus reference number [line item], plus service date).

If the chance to submit corrections expires after one year, a database must be maintained with all claims for up to a year.

Provider Submits a Correction for Less Than Originally Billed:

If the provider submits an electronic correction (resubmit) to a previously submitted claim for LESS than originally billed, the responding 835 must contain adjustment codes.

I.G., p. 28: "When a claim is paid in error, the method for correcting it is to reverse the original claim payment and resend the corrected data."

Reversing means that the original 835-RA is resent, but flagged as a reversal. Then the corrected 835-RA is sent.

If the transaction level balance goes negative, an additional **provider level adjustment** must be added to bring the balance up to zero. This balance forward amount must be stored and subtracted from the provider's next payment as another adjustment. Both the first and second remittance will have a balance forward adjustment, the first time to bring the balance up to zero, the second time to subtract that same amount.

Currently corrections are made by AFRS not by the SSPS system, corrections made by AFRS do not go into the SSPS system, and OFM creates a minimal RA and sends it to the provider with check. Under HIPAA, the provider can expect to receive all corrections to 835s from SSPS.

4.6.3 835: Store Data From Claim

The following data used in the 835 should be stored and returned from the 837 Claim. These are cases where entire segments should be stored and returned.

Loop	Segment	Data Element	Comment
Header	REF	Receiver ID	
Claim	CLP01	Patient Account Number	Provider's ID for client
Claim	NM1	Patient Name and ID	If differs from original in 837, return both original and corrected name
Claim	DTP	Claim Date	
Service	SVC	Service Payment Information	
Service	DTP	Service Date	
Service	REF	Service ID	

4.6.4 835: HIPAA Code Set Usage

Beyond the format and data elements that must be used, the implementation guides for the HIPAA transaction dictate the required code sets to be utilized in certain data elements.

Loop	Segment	Data Element	Legacy Field	HIPPA Code Set
Service	SV101	Procedure Code	SERVICE CODE	Map to HCPCS codes

4.6.5 835: Looping

HIPAA transaction formats contain complex looping structures to allow repetition of sets of related data. The software that parses the incoming transaction will need to accommodate optionally:

- Multiple claims in one transaction,
- Multiple service line items for each claim (up to 999 for 837I).